ADA 2006 Dental Claim Form

FIELD NAME	INSTRUCTIONS
1. Type of Transaction	Enter an "X" in the appropriate box.
2. Preauthorization Number	Prior authorization number if applicable.
3. Insurance Company Plan	Enter the plan name, address, state and zip code.
4. Other Coverage	Check Yes or No to indicate whether or not the services are covered by any other insurance**. (Yes must be checked if other insurance is listed in form locator 11.)**
5. Name of Policy Holder	Enter last, first name and middle initial of policy holder.
6. Date of Birth	Enter date of birth of policy holder in MMDDCCYY format.
7. Gender	Check appropriate box for gender of policy holder.
8. Policy Holder ID	Enter subscriber identification.
9. Plan Number	Enter policy or group number.
10. Patient's Relationship to Insured	Check appropriate box.
11. Other Insurance Company	Enter the three digit carrier code and name of any other insurance the patient has. **Note**: The other insurance carrier must be billed first.
12. Policy Holder	Enter policy holder name and address for insurance named in location 3.
13. Date of Birth	Enter date of birth of policy holder in MMDDCCYY format.
14. Gender	Check appropriate box.
15. Policy Holder ID	Enter RI Medical Assistance identification number.
16. Plan Number	Enter plan number.

17. Employer Name	Enter name of employer if applicable.
18. Relationship to Policy Holder	Check appropriate box.
19. Student Status	Check appropriate box if applicable.
20. Patient's Name and Address	Enter last name, first and middle initial of patient as it is displayed on their Medical Assistance Card. Enter the street, city and zip code of the patient.
21. Date of Birth	Enter date of birth of patient in MMDDCCYY format.
22. Gender	Check appropriate box.
23. Patient ID	Enter patient account number.
24. Procedure Date	Enter the date for this service in MMDDCCYY numeric format.
25. Area of Oral Cavity	Enter 1 or 2 digit code identifying the area of the oral cavity in which the service is rendered. 00 Entire Oral Cavity 01 Maxillary Area 02 Mandibular Area 09 Other area of Oral Cavity 10 Upper Right Quadrant 20 Upper Left Quadrant 30 Lower Left Quadrant 40 Lower Right Quadrant L Left R Right
26. Tooth System	
27. Tooth Number(s)	Enter appropriate tooth number or letter.

28. Tooth Surface	Enter 1 digit code for tooth surface. B Buccal D Distal F Facial I Incisal L Lingual M Mesial O Occusal
29. Procedure Code	Enter the 5 character HCPCS code that describes each procedure performed.
30. Description	Enter description of procedure performed.
31. Fee	Enter the UCR amount charged for each procedure performed.
32. Other Fees	Enter any other fees.
33. Total Fee	Enter the total of the charges for this claim, (the sum of the detail lines in block 31).
34. Missing Teeth Information	Place an X on each missing tooth.
35. Remarks	Enter additional information to adjudicate the claim.
36. Authorization	Patient/guardian signature or “signature on file.”
37. Authorization	Subscriber signature or “signature on file.”
38. Place of Treatment	Check appropriate box for service location.
39. Number of Enclosures	Enter information as appropriate.
40. Treatment for Orthodontics	Check appropriate box. If no is checked skip 41-42.
41. Date Appliance Placed	Enter the date of placement in MMDDCCYY format.
42. Months of Treatment	Enter the number of months remaining for treatment.

Remaining	
43. Replacement of Prosthesis	Check appropriate box.
44. Date Prior Placement	Enter the date of prior placement in MMDDCCYY format.
45. Treatment Resulting From	**Check appropriate box if treatment is a result of an occupational illness, auto accident, or other accident. If accident complete b**
46. Date of Accident	Enter the date of accident in MMDDCCYY numeric format.
47. Auto Accident State	Enter the two digit state identifier.
48. Billing Dentist	Enter the billing dentist name, address and zip code.
49. NPI	Enter the billing or group National Provider Identifier. **If a group; enter the group NPI.**
50. License Number	**If NPI is entered in block 49, taxonomy code must be entered.**
51. SSN or TIN	Enter the social or tin of the billing provider.
52a. Additional Provider ID	Enter seven digit Medicaid provider ID.
53. Signature	Enter the authorized signature of the billing provider or supplier. (Stamps or initials are not acceptable.) Also enter the date the claim is signed.
54. NPI	Enter the NPI of the treating dentist. **Required if a member of a group.**
55. License Number	Enter treating provider license number.
56. Address	Enter address of treating dentist if different than block 48.
56A. Provider Specialty Code	**If NPI is entered in block 54, taxonomy code must be entered.**
57. Phone Number	Enter phone number of treating dentist if different than block 52.
58. Additional Provider ID	Enter treating dentist seven digit Medicaid ID.